Nebraska Division of Behavioral Health (DBH)

Statewide Quality Improvement Team (SQIT)

December 5, 2012 / 2:00-4:00 p.m.

DBH/Live Meeting

Meeting Minutes

I. Welcome and Attendance — *Heather Wood*

Heather welcomed everyone to the meeting and introductions were made.

Region 1:	Laura Richards
Region 2:	Nancy Rippen, Theresa Ward
Region 3:	Ann Tvrdik
Region 4:	Amy Stachura, Amanda Theisen
Region 5:	Kathleen Hanson, Linda Wittmuss, Patrick Kreifels, Christine McCollister
Region 6:	Stacey Brewer, Dan Jackson, Kindra Seifert, Joe Dulka
DHHS - Medicaid:	Staci Zuerlein
DHHS - Division of Behavioral Health:	Heather Wood, Carol Coussons de Reyes, Cody Meyer, Jan Goracke, Jim Harvey, Maya Chilese, Patrick Johnson, Robert Bussard, Susan Adams, Kelly Dick (recorder)

II. Review of Agenda & Minutes — *Heather Wood*

1. Heather reviewed the current agenda. The day's outcome focus was on:
    a. Priorities for FY14/FY15
    b. Consumer Survey Communication Improvement Workgroup Recommendations
    c. Evidence Based Practices Workgroup Recommendations
2. The floor was opened for comments on the minutes from the September 5, 2012 meeting. There was no discussion.

ACTION ITEMS	PERSON RESPONSIBLE	DEADLINE/RESULT
Approve September 5, 2012 minutes.	Group	Approved

III. Block Grant (BG) Review — *Heather Wood, Bob Bussard, Cody Meyer*

1. Review of BG Reporting and Application Steps (Bob)

- The FFY13[1] combined MH/SA BG application has been submitted (due September 1, 2012).
- The SFY12[2] SA and MH BG reports were submitted (due December 1, 2012).
- The FFY13 SABG Synar report has been submitted (due December 31, 2012).
- Next steps due April 1 2013:
    - ✓FFY 2014 combined MHSBG & SAPTBG "application."
    - ✓SFY 2014/2015 combined MHSBG & SAPTBG "plan."

[1] FFY=Federal Fiscal Year (October 1 - September 30)

[2] SFY=State Fiscal Year (July 1 - June 30)

- BG application requirements:
  - ✓Planning process includes available data to identify the strengths, needs, and service gaps for specific populations.
  - ✓By identifying needs and gaps, states can prioritize and establish tailored goals, strategies, and measurable targets.
- DBH State Priorities - Planning
  - ✓Needs Assessment: Step 1) Assess the strengths and needs of the service system to address the specific populations. Step 2) Identify the unmet service needs and critical gaps within the current system.
  - ✓Priority Activities: Step 3) Prioritize state planning activities.
  - ✓Strategies and Indicators (measure progress toward achieving goals): Step 4) Develop objectives, strategies, and performance indicators.

2. Needs Assessment (Cody - Handout Attached)

- Cody reviewed the attached document, noting:
  - ✓Step 1: Strengths and Needs of the Service System to Address Specific Populations (Profile of Individuals Receiving Service).
  - ✓Step 2: Needs Assessment (Considerations related to current priorities).
  - ✓Additional Considerations.

3. Priority Planning Discussion (Heather)

- Data should be pertinent to our services, the work we have ongoing and to our consumers' needs.
- What does the continuation of the work look like and what other areas should be considered for which we don't have a FY 12/13 priority?
- Comments included the topics of Housing, Suicide, State Hospitals, Schizophrenia, and Overall Wellness.
- Discussion:
  - ✓A question regarding housing was raised and Jim Harvey clarified that in Nebraska, Permanent Supported Housing, for the purpose of fidelity monitoring is limited to Housing Related Assistance (HRA). There is a single administrative body that pulls HRA together. Heather suggested that Housing be a topic for the next SQIT agenda.
  - ✓Instance of smoking in MH consumers may be higher than data shows. One member of SQIT mentioned data showing that 94% of women and 80% of men with schizophrenia smoke. Goal: Educate consumers to the risk / the nature of the relationship between the mental illness and smoking / educate about tax dollars involved.
  - ✓Heather encouraged the group to forward data such as this (along with the original source) to her or another member of the DBH Data Team.

IV. Consumer Survey — *Patrick Johnson, Heather Wood*

1. DBH 2012 Consumer Survey Results

- Patrick reviewed resulting data from the 2012 Consumer Survey. The final report for 2012 will be available on the DBH web site once it is complete. The Summary of Results for the 2011 Consumer Survey is available at www.tinyurl.com/2011summary.
- The survey is given to a random sample of adults and youth that received services July through December of the previous year. The survey is administered in the spring. The respondent demographics for the 2012 adult survey are:
  - ✓Age:
    - 19-24 years: 298 (13.8%)
    - 25-44 years: 872 (40.5%)

- 45-64 years: 896 (41.6%)
- 65+ years: 87 (4.0%)

✓Gender
- Male: 980 (45.5%)
- Female: 1173 (54.5%)

✓Race:
- White: 1830 (85.0%)
- Non-White: 216 (10.0%)
- Multi-racial: 74 (3.4%)

✓Ethnicity:
- Hispanic: 137 (6.4%)
- Non-Hispanic: 1981 (92.0%)

- The survey covers seven domains consisting of multiple questions each. These domains are: Access, Quality and Appropriateness, Outcomes, Participation in Treatment Planning, General Satisfaction, Functioning, and Social Connectedness.
- In 2012 the survey was administered to three random groups of individuals with differing modes of contact/response (Group 3 was categorized separately as mail only because phone numbers were unavailable for those consumers):

	Group 1		**Group 2**		**Group 3**
# of sample	2767		2768		706
# of contacts	2232		1824		237
contact rate	80.7%		65.9%		33.6%
	PHONE	MAIL	MAIL	PHONE	MAIL
# of completes	833	244	560	439	77
	1077		999		77
response rate	48.3%		54.8%		32.5%

- Group 1 received a follow up contact mode of mail and Group 2 a follow up contact mode of phone. Had there been no follow up mode for these two groups, the response rates would have been 37% and 30% respectively. The two-mode approach appears to be beneficial.
- Patrick noted some additional data regarding mode:
  - ✓Consumers placed in Group 1 responded significantly more positively to all domains except *Access*.
  - ✓For Group 2, consumers responding via telephone responded significantly more positively than those responding via mail (only Group 2 allowed for mode comparison. The Group 1 file was received as one file rather than split by mode of response).
- The open-ended question coding scheme was briefly summarized.
- 2012 Consumer Survey Summary:
  - ✓Response rate for adult survey increased from 43% in 2011 to 50% in 2012.
  - ✓The % of positive responses remains fairly constant from 2010 to 2012 for most domains, with the lowest in Outcomes domain and the highest in Quality and Appropriateness (Q&A) domains.
  - ✓Consumers who stay 1 year and more respond significantly more positively to Access, Q&A, Outcomes, and General Satisfaction questions than those who stay less than 1 year.
  - ✓The lowest % of positive responses domain (Outcome) still got 74% satisfaction rate.

- ✓Consumers who received MH services are significantly more likely to have angina/coronary heart disease and diabetes than SA consumers.
- ✓More consumers (77%) than MH consumers (64%) who received SA services report good, very good, or excellent health condition.
- ✓Significantly more consumers (46%) than SA consumers (26%) who received MH services report their Body Mass Index at an obese level.
- ✓56% of consumers who received SA services smoke everyday compared to 40% of MH consumers and 15% of the general population in Nebraska.

- Comments:
  - ✓Look at other states for best practices and methodology.

2. Consumer Survey Communication Improvement (CSCI) Workgroup Update & Recommendations

- The Charge of the CSCI Workgroup is to provide recommendations to DBH leadership (SQIT) by on an efficient way of improving overall communication of and participation in the DBH Consumer Survey. The goal is to get improved information out to consumers in order to achieve better understanding, higher trust, and increased participation.
- The Workgroup developed a brochure and flyer for 2013 data collection (PDF samples of these are available by request. Contact Kelly Dick at kelly.dick@nebraska.gov). The flyer includes general information about the survey and could be reused annually. The tri-fold brochure includes general information and some specific findings and would need to be reprinted annually to update specifics. The slogan to be used within the flyer, brochure, and survey notification letters is "We Value Your Voice."
- Cost of 10,000 color brochures: $890; 200 color 8.5 x 11 flyers: $82 (source: DAS)
- Additional communication already in use includes:
  - ✓Pre-notification letter (informs respondent they have been selected, the purpose of the study, and how to participate).
  - ✓Mail cover letter (sent a few days later with the physical survey - includes general information, an appeal for help, and confirmation of confidentiality.
  - ✓Reminder letter (brief, i.e. waiting to hear back from you).
  - ✓Mail phase 2 letter (for those that were contacted by phone without success - includes general information, an appeal for help, and confirmation of confidentiality).
- Comments or Concerns include:
  - ✓Costs and the funding source for printing are a concern. Who will fund?
  - ✓The brochure/flyer would prepare people for the survey.
  - ✓Perhaps include the flyer (not the brochure) with the survey in the mail.
  - ✓Suggestion was made to look into costs for printing through the Center for People in Need.
  - ✓Perhaps the brochure and flyer can be emailed to distributers, such as physical health providers, so if they choose to share they carry the costs.
  - ✓Region 1 suggested including the brochure in the intake packets when a consumer comes in to a service.
  - ✓Region 4 has the capability of doing some of the (supplemental) printing themselves.
  - ✓Please send additional recommendations/feedback to Heather.

ACTION ITEMS	PERSON RESPONSIBLE	DEADLINE/RESULT
Investigate printing costs at Center for People in Need.	Patrick Johnson	ASAP
Send further feedback about Consumer Survey flyer/brochure to Heather.	Group	ASAP

V. Quality Initiatives - Updates *Carol Coussons de Reyes, Heather Wood, Jim Harvey, Group*

1. **QI Handbook Update (Carol)**
   - Chapters have been assigned to members of the group and work continues.
2. **Co-Occurring Disorder (COD) Workgroup Update (Heather)**
   - The Workgroup has partnered with Mary O'Hare who will help the group move toward next steps and align with the Division Strategic Plan. More information will be shared in the months to come.
3. **Evidence Based Practices (EBP) Workgroup Update and Recommendations (Jim) - Handout Attached 1:42**
   - The Charge of the Evidence Based Practices Workgroup is to provide recommendations to DBH leadership by September 29, 2012 on a consistent and sustainable way of doing fidelity monitoring linked to outcomes on Evidence Based Practices. Using EBPs is an investment in what works. The goal is to improve the use of EBPs in order to achieve more effective use of limited community resources.
   - A note on children services:
     - ✓ It was determined that these would be addressed after a new Director for the Division of Children & Family Services had been appointed.
   - Jim reviewed the attached document that highlights recommendations made by Dr. Blaine Shaffer and the EBP Workgroup regarding four EBPs:
     - ✓ Assertive Community Treatment (ACT)
     - ✓ MedTEAM (Medication Treatment, Evaluation, and Management)
     - ✓ Permanent Supportive Housing
     - ✓ Supported Employment
     - ✓ Integrated Treatment for Co-Occurring Disorders was originally going to be addressed by the EBP Workgroup, but will instead be covered by the before-mentioned COD Workgroup in the coming months.
   - Comments:
     - ✓ Grants and other funding options will be looked into to cover costs of the ongoing fidelity monitoring of these and other services.
4. **Call for Additional QI Updates (Group)**
   No other updates were volunteered.
5. **Additional Comments:**
   Are we missing a group of people when we look at data? There is a large contingency in the U.S. that believes trauma should be the focus rather than the diagnosis.

VI. Items for Next Agenda *Group*

- Housing
- Team may share additional agenda items with Heather as they arise.

VII. Adjournment and Next Meeting

- Thanks to team on phone and in person.
- Meeting was adjourned at 4:00 p.m.
- Next Meeting is scheduled for Wednesday, March 6, 2013, 2:00 – 4:00 p.m. Central Time.
- Please watch for invitations for 2013 SQIT quarterly meetings.

Minutes prepared by the Division of Behavioral Health, Nebraska Department of Human Services. Minutes are intended to provide only a general summary of the proceedings.

Block Grant Planning Steps – for discussion at SQIT meeting on December 5, 2012

Step 1: Strengths and Needs of the Service System to Address Specific Populations

Profile of Individuals Receiving Service:

- In FY2012, there were 23,535 individuals who were served in MH services and 15, 544 individuals who were served in SA services.
- There were 15, 092 adults served with SMI; 1,340 youth with SED. SMI and SED consumers received 8, 692 Evidence Based Practice services.
- The readmission rate to any state run psychiatric inpatient hospital is extremely low; only 2% within 30 days and 5% within 180 days for non-forensic and less than 1% within 30 days and 7% within 180 days for forensic.
- We have continued to experience an increase in our response rates to the annual consumer survey. 50% of adult consumers and youth caregivers surveyed provided feedback regarding their behavioral health care. A majority of adult consumers (83.6%) were generally satisfied with services compared to those who were dissatisfied with the services they received (6.5%); the remainder were neutral.
- In FY2011, employment for adult consumers in NE (in the labor force) was much higher than the national average (53% Nebraska vs. 35% US).
- There has been tremendous work and success toward the FY2012/2013 priorities.

Step 2: Needs Assessment

Considerations related to current priorities:

- The rate of underage drinking appears to be on the rise particularly for males. Recent Nebraska Young Adult Alcohol Opinion Survey results revealed that the rate of males ages 19 to 20 that binge drink is at 40% (FY2012); up from 26% just two years ago (FY2010). Additionally for this group, 78% showed an increase in their perception that there is little to no risk in binge drinking once or twice a week. National data shows that 56% of adolescents report using their first primary substance between 12 and 14.
- Consumers who report trauma continues to increase. 42% of individuals receiving services reported a history of trauma during FY2012 compared to 28% in FY2010. Nationally it is estimated that 55 to 99% of women in substance use treatment and from 85 to 95% of women in the public mental health system report a history of trauma. Trauma is now considered to be a near universal experience for those with behavioral health problems.
- The number of individuals served in both a mental health and substance abuse or dual service has risen to nearly 10% in FY2012. NAMI reports that roughly 50% of individuals with severe mental disorders are affected by substance abuse while 37% of alcohol abusers and 53% of drug abusers also have at least one serious mental illness. Comparison of FY2011 data shows that Nebraska has a higher than national rate of adults and children served who have co-occurring disorders (26% Nebraska vs. 21% US).

Additional Considerations:

- The length of stay based on discharge data at LRC has increased from 2011 to 2012. A quality improvement initiative began in October 2012 to identify causes and make improvements.
- 2010 data shows that Nebraska tends to be consistent with the national average for serious thoughts of suicide in the general public (4% for both Nebraska and US). Research shows that more than 90% of patients who die by suicide have mental illnesses or substance use disorders. Both Whites and American Indian/Alaskan Natives have higher suicide rates than other racial groups. Rural areas have also have shown higher suicide rates than metropolitan areas.
- Homelessness in FY2011 was higher in Nebraska (5.1%) than the US average (3.1%). In FY2012, 5.8% receiving services reported homelessness.
- 40% of individuals served in FY2012 live in rural areas. National data suggests that rural admissions to behavioral health services are more likely to be referred by criminal justice and report alcohol as their primary substance.
- 6% served in FY2012 reported themselves as military personnel.
- When asked whether they smoke cigarettes on the 2012 consumer survey, 40% of mental health consumers indicate that they smoke every day. Likewise, 56% of consumers with substance use disorders report smoking every day. These numbers are compared to 15% of the NE general population who report daily smoking.
- Caregiver reports through the youth consumer survey show that in FY2011 67% were satisfied with access to services for NE youth compared to the US rate of 83%.

SUMMARY: Evidence Based Practices Workgroup Recommendations

The Evidence Based Practice	Fidelity Monitoring Toolkit	Frequency	Potiential People Involved	Recommendations
1. MedTEAM (Medication Treatment, Evaluation, and Management)	Use SAMHSA Toolkit	3 Years	External Fidelity Monitoring Visit Staffing - Administrative Lead responsible for organizing and managing the external fidelity monitoring visit. - EBP Provider with specific NE experience with the type of service - One Regional Behavioral Health Authority staff - One Certified Peer Support and Wellness Specialist who had received the EBP service	Each EBP provider tracking processes needed to improve.
2. Assertive Community Treatment (ACT)	Use Tool for Measurement of Assertive Community Treatment (TMACT)	2 years		
3. Permanent Supportive Housing	Use SAMHSA Toolkit. Limit the review to just the NE Housing Related Assistance program.	2 years		
4. Supported Employment	- Use of the Dartmouth Individual Placement & Support (IPS) is being considered - or -	2 years		
	SAMHSA Supported Employment Tool kit	2 years		
	- "Nebraska model" based on SAMHSA Supported Employment Tool kit developed in partnership between DBH and State Vocational Rehabilitation.	2 years		

Next Steps:

Statewide Quality Improvement Team (SQIT) review on December 5, 2012.

Regional Behavioral Health Authorities review (to be scheduled).

Division of Behavioral Health discussions.

Other Issues:

- Workforce issues (who will do this work, training, related concerns).
- Costs (how to pay for the work to be done and related concerns).
- Time (when will this work be done?)
- Implementation starts with each EBP Provider preparing:
  - Year 1 - Receives Technical Assistance (TA) and training
  - Year 2 - Practice doing EBP - internal QI processes
  - Year 3 - The external fidelity monitoring review

"EBP Provider" means the organization is under contract for the service with a Regional Behavioral Health Authority.